Landing Page

Inclusion Criteria

Bronchiolitis signs and symptoms in patients ≤ 24 months (Annotation A):

- upper respiratory tract involvement (fever, rhinorrhea, nasal congestion, cough)

AND

- lower respiratory tract involvement (fever, tachypnea, wheezing, rales, increased work of breathing)

Exclusion Criteria:

- Symptoms most consistent with asthma/bronchospasm or other alternative diagnosis (Annotation B)
- Significant underlying heart disease
- Neurological disease or neuromuscular weakness

Clinical Diagnosis/Workup Recommendations:

Bronchiolitis is a clinical diagnosis. The following tests and treatments are **NOT** routinely indicated:

- Chest x-ray
- Laboratory tests including respiratory panels, CBC, blood culture
- Medications including albuterol, steroids, racemic epinephrine, hypertonic saline, or antibiotics

Patient ≤ 24 months presenting with signs and symptoms of bronchiolitis & no exclusions

Is the patient less than 60 days old?

Yes

- Consider septic workup if ill appearing

and/or

- Febrile Neonate Guideline if febrile

No

Perform holistic assessment (Annotation C) including:

- vital signs
- work of breathing
- mental status
- hydration/feeding
- social drivers of health
- RSV immunization status (Appendix A)

Initial Supportive Care

- Nasal or nasopharyngeal suctioning as needed
- Supplemental O_2 to maintain $SpO_2 \geq 90\%$
- Offer PO feeds
- Antipyretics as needed

Where is the patient being seen?

- Outpatient Management
- Emergency Room Management
- Hospital: Acute Care Management
- Hospital: Critical Care Management

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Bronchiolitis

Clinical Guideline

Outpatient

Start at landing page for initial assessment and supportive care

Perform a holistic reassessment after initial supportive care provided (Annotation C)

Is patient in visible respiratory distress and/or requiring supplemental O_2 to maintain $SpO_2 \geq 90\%$?
Assess for: retractions, nasal flaring, head bobbing, grunting, tachypnea, hypoxia

No

Yes

Provide additional nasal or nasopharyngeal suctioning

Concern for:
- Persistent or worsening respiratory distress
- Hypoxia requiring supplemental O_2 > 2L

Yes

Activate Emergency Response
- Call 911 & transfer to emergency department
- Provide supportive care & BLS until ambulance arrives
- Provide nasal suction, and supplemental O_2 to maintain $SpO_2 \geq 90\%$

No

Is ≤ 2L O2 required to maintain $SpO_2 \geq 90\%$?

No

Yes

Does the patient have adequate PO intake to maintain hydration?

No

Perform PO trial

Passed PO trial?

Yes

No

Yes

Does patient meet discharge criteria*?

No

Follow direct admission process (Annotation D)**

Yes

Discharge

*** Discharge Criteria**

- Tolerable work of breathing
- No need for supplemental oxygen
- Suctioning at home capability
- Tolerating adequate PO intake to maintain hydration
- Caregiver comfortable with home plan
- Access to follow-up care

Discharge Plan

- Provide RSV immunization if appropriate & available at your care location (Appendix A)
- Caregiver education on suctioning, hydration, anticipatory guidance, and return precautions
- Provide bronchiolitis AVS and Digital Care Bundle (bulb/nasal suction) if available for your location
- Follow-up instructions

**** Direct Admission Considerations**
(See Annotation D)

- Hypoxia requiring ≤2L supplemental O2 after interventions
- Continued intolerance of work of breathing despite interventions (retractions, nasal flaring, head bobbing, grunting, tachypnea)
- Hydration support

Emergency department transfer considerations
- Worsening work of breathing
- Age < 3 months
- Gestational age < 48 weeks corrected
- Apnea (Annotation E)
- Underlying cardiac or pulmonary disease
- Anticipated to require HFNC
- Dehydration requiring IV fluids

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Bronchiolitis

Clinical Guideline

CW EDTC & Outside Emergency Departments

Start at landing page for initial assessment and supportive care

Perform a holistic reassessment after initial supportive care provided (Annotation C)

Is the patient tolerating WOB on current therapy?*

- **No**
  - Provide additional nasal or nasopharyngeal suctioning
  - Consider HFNC (Annotation F)
  - Consider alternative diagnoses (Annotation B)
  - On reassessment does patient meet any of the following **critical care criteria**:
    - Clinical status worsening on optimized HFNC settings
    - HFNC setting above maximal acute care settings (Annotation F)
    - Recurrent apnea (Annotation E)
    - Need for non-invasive or invasive mechanical ventilation
    - Fluid refractory shock
  - **Yes** → **Admit to Critical Care**
  - **No** → **Admit to Acute Care**

      Location Specific Admission Considerations (Annotation G)
- **Yes**
  - Is supplemental O2 required to maintain SpO2 ≥ 90%?
    - **Yes** → **Admit to Acute Care**
    - **No**
      - Does the patient have adequate PO intake to maintain hydration?
        - **Yes**
        - **No** → Perform PO trial → Passed PO trial?
          - **No** → **Admit to Acute Care**
          - **Yes**
      - Does patient meet discharge criteria**?
        - **No** → **Admit to Acute Care**
        - **Yes** → **Discharge**

**** Discharge Criteria**

- Tolerable work of breathing
- No need for supplemental oxygen
- Suctioning at home capability
- Tolerating adequate PO intake to maintain hydration
- Caregiver comfortable with home plan
- Access to follow-up care

Discharge Plan

- Provide RSV immunization if appropriate & available at your care location (Appendix A)
- Caregiver education on suctioning, hydration, anticipatory guidance, and return precautions
- Provide bronchiolitis AVS and/or Digital Care Bundle (bulb/nasal suction) if available for your location
- Follow-up instructions

*** Signs that patient is NOT tolerating their increased WOB**

- Inability to coordinate suck/swallow/breathing for feeds
- Persistent tachycardia despite adequate fluid resuscitation
- Change in mental status (inconsolable, lethargic)
- Hypoxia despite supplemental oxygen via LFNC

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Bronchiolitis

Clinical Guideline

Start at landing page for initial assessment and supportive care

Follow the admission process (Annotation H)
including ordering the RCS Bronchiolitis Protocol (Annotation I)

Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

Is the patient tolerating WOB on current therapy?*

Yes

Maintain or de-escalate interventions per RT protocol (Annotation I)
Consider changes to:
- Suction
- Oxygen & respiratory support
- Pulse Ox
- Hydration (Annotation J)

Does patient meet discharge criteria**?

Yes → **Discharge**

No →
- Consider alternative diagnoses (Annotation B)
- Allow time for recovery

→ Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

No

Escalate support per RT protocol (Annotation I)
Consider changes to:
- Suction
- Oxygen and respiratory support: Consider HFNC (Annotation F)
- Hydration (Annotation J)

Consider adjunct therapies (Annotation K)
Consider alternative diagnoses (Annotation B)

Is clinical status worsening?

No → Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

Yes →

Consider RRT or Code Blue as needed for further respiratory support

On reassessment does patient meet any of the following critical care criteria:
- Clinical status worsening on maximal acute care HFNC setting (Annotation F)
- Recurrent apnea (Annotation E)
- Need for non-invasive or invasive mechanical ventilation
- Fluid refractory shock

No → Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

Yes →

Transfer to Critical Care

**** Discharge Criteria:**

- Tolerable work of breathing
- Tolerable tachypnea in past 4 hours
- Stable SpO2 ≥ 90% on room air for at least 4-6 hours. Consider longer observation for high-risk patients (Annotation L)
- Suctioning at home capability
- Tolerating adequate PO intake to maintain hydration with adequate urine output (Annotation C)
- Caregiver comfortable with discharge plan
- Access to follow-up care

Discharge Plan

- Provide RSV immunization if eligible (Appendix A)
- Caregiver education on suctioning, hydration, anticipatory guidance, and return precautions
- Provide bronchiolitis AVS and Digital Care Bundle (bulb/nasal suction)
- Follow up plan: Confirm PCP in Epic & recommend as needed follow up (Annotation M)

***Signs that patient is NOT tolerating their increased WOB**

- Inability to coordinate suck/swallow/breathing for feeds
- Persistent tachycardia despite adequate fluid resuscitation
- Change in mental status (inconsolable, lethargic)
- Hypoxia despite supplemental oxygen via LFNC

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Bronchiolitis

Clinical Guideline

Start at landing page for initial assessment and supportive care

Follow the admission process (Annotation H)
including ordering the RCS Bronchiolitis Protocol (Annotation I)

Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

Is the patient tolerating WOB on current therapy?*

Yes

Maintain or de-escalate interventions per RT protocol (Annotation I)
Consider changes to:
- Suction
- Oxygen & respiratory support
- Pulse Ox
- Hydration (Annotation J)

Does patient meet discharge criteria**?

Yes → **Discharge**

No

Does patient meet criteria for transfer to acute care?

Yes → **Transfer to Acute Care *** *Consider changing vital signs to Q4H and spot check SpO_2 (once off O2 for 4 hours) while awaiting transfer*

No

- Consider alternative diagnoses (Annotation B)
- Allow time for recovery

→ Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

No

Escalate support per RT protocol (Annotation I)
Consider changes to:
- Suction
- Oxygen & respiratory support: HFNC, CPAP, BiPAP, NIV NAVA, or intubation with mechanical ventilation as needed
- Hydration: Make NPO w/ IVF if escalating beyond HFNC

Consider adjunct therapies (Annotation K)
Consider alternative diagnoses (Annotation B)
Consider sepsis work up and/or chest XR

→ Perform a holistic reassessment of vital signs, work of breathing, mental status, and hydration/feeding (Annotation C)

**** Discharge Criteria:**

- Tolerable work of breathing
- Tolerable tachypnea in past 4 hours
- Stable SpO2 ≥ 90% on room air for at least 4-6 hours. Consider longer observation for high risk patients (Annotation L)
- Suctioning at home capability
- Tolerating adequate PO intake to maintain hydration with adequate urine output (Annotation C)
- Caregiver comfortable with discharge plan
- Access to follow-up care

Discharge Plan

- Provide RSV immunization if eligible (Appendix A)
- Caregiver education on suctioning, hydration, anticipatory guidance, and return precautions
- Provide bronchiolitis AVS and Digital Care Bundle (bulb/nasal suction)
- Follow up plan: Confirm PCP in Epic & recommend as needed follow up (Annotation M)

*** Signs that patient is NOT tolerating their increased WOB**

- Inability to coordinate suck/swallow/breathing for feeds
- Persistent tachycardia despite adequate fluid resuscitation
- Change in mental status (inconsolable, lethargic)
- Hypoxia despite supplemental oxygen via LFNC

***** Transfer Criteria to Acute Care**

- No apnea requiring intervention x 24 hours (Annotation E)
- Tolerating WOB/ oxygenation with ≤15LPM, ≤2LPM/kg and weaning, with ≤0.60 FiO2 for 4 hours
- Tolerating WOB = ability to coordinate suck/swallow/breathing without NP suctioning more frequently than every 1-2 hours
- Hemodynamically stable

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Annotations (A-E)

A. **Bronchiolitis** is a viral lower respiratory tract infection in patients aged 0-24 months. It is characterized by acute inflammation, edema, and necrosis of epithelial cells lining small airways, and increased mucus production. Clinical manifestations often include rhinorrhea, rhinitis, cough which can progress to tachypnea, wheezing, rales, and increased work of breathing with associated nasal flaring and/or use of accessory muscles. Upper respiratory tract infection symptoms (such as fever, rhinorrhea and nasal congestion) typically precede lower respiratory tract involvement by 3-7 days, and peak of illness is typically day 4-7 of illness, however patients can have a variable course. Symptoms last an average of 10-14 days, but they can last 21 days or longer, particularly in patients with risk for severe disease. Apnea may also occur in infants less than 3 months of age and may precede other symptoms.

B. **Differential Diagnosis** includes but is not limited to asthma/bronchospasm, pneumonia, aspiration, pertussis, chlamydia trachomatis pneumonia, foreign body, pneumothorax, croup or upper airway obstruction, pulmonary edema, cardiac disease, and/or sepsis.

C. **Holistic Assessment** of patients with bronchiolitis should include considerations of:

1. Vitals: Assess for tachycardia, tachypnea, and hypoxia. Address fever with antipyretics. Persistent tachycardia and/or hypotension despite adequate fever control and fluid resuscitation should raise concern for sepsis.
2. Work of breathing: Assess for retractions, nasal flaring, head bobbing, grunting, and tachypnea.
3. Mental Status: Significant change in mental status including either inconsolability or lethargy may be a sign of respiratory failure or alternative diagnosis and should prompt additional evaluation.
4. Hydration/Feeding: Infants with bronchiolitis are at risk for dehydration and poor feeding due to impaired ability to coordinate suck/swallow/breathing due to nasal obstruction and increased insensible losses. If PO intake remains poor despite adequate suctioning, consider NG or IV fluids (Annotation J). Consider the following as approximate targets for adequate intake:
    - <6 months: ≥75% fluid requirement
    - 6-12 months: ≥50% fluid requirement
    - >1 years: ≥50% fluid requirement OR 50% typical solid intake + ≥ 25% fluid requirement
5. Urine output: Monitor urine output due to risk of dehydration. Target adequate urine output:
    - <1 year ≥1 mL/kg/hr
    - >1 years ≥0.5 mL/kg/hr
6. Social drivers of health: Review SDOH screening results and follow location specific workflow to address any unmet social needs identified. In particular, assess for access to hydration/nutrition, ability to obtain medications and suctioning equipment, environmental exposures (smoke, mold, etc), and access to care, all of which may directly impact bronchiolitis illness course.
7. RSV immunization status: Nirsevimab protects infants from RSV and is available to give to eligible infants between October 1st and approximately March 31st (end date may be extended based on RSV prevalence). To assess eligibility, ask if the pregnant person received the RSV vaccine during this pregnancy and whether it was given at least 14 days prior to delivery. Enter this into the birth history tab. Then assess the patient's age and eligibility as outlined in Appendix A, a summary of the AAP Policy Statement on RSV Prevention. Provide Nirsevimab to eligible infants.

D. **Direct Admission Process:**

1. **Milwaukee Campus:** Follow your location specific current process for direct admission on Learning Home. If no established process or unsure, contact the Provider Contact Center at (414) 266-2460 or toll-free at (800) 266-0366.
2. **Fox Valley Campus:** For locations with an established partnership with Mission Control, call 414-266-2460. For all other requests for admission, please page the Fox Valley Hospitalist at pager (920-554-4502). Final determination of ability to direct admit a patient is at the discretion of the pediatric hospitalist.

E. **Apnea:** Apnea is typically defined as a cessation of respiratory effort lasting ≥ 20 seconds or shorter episodes accompanied by bradycardia, cyanosis, or hypotonia. Apnea may occur in infants with bronchiolitis. Risk factors for apnea during bronchiolitis hospitalization include age 0 to 8 weeks (especially those <2 weeks), birth weight <2.3 kg, caretaker report of previous apnea during this bronchiolitis episode, preadmission respiratory rates of <40 or >70, and having a preadmission room air oxygen saturation <90%. Any patient with a history of apnea should be kept on continuous pulse oximetry monitoring regardless of oxygen requirement. If apnea episodes are frequent, prolonged, or requiring significant stimulation, recommend admission/transfer to critical care for additional monitoring.

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Annotations (F-I)

F. High-flow nasal cannula: Heated, humidified, high flow nasal cannula (HFNC) is a device to safely provide higher flows than can be delivered by standard nasal cannula (LFNC) and thus may provide a higher FiO2 and possibly a limited amount of positive pressure. HFNC has not been shown to reduce illness severity or decrease length of stay in patients admitted with bronchiolitis. HFNC is best used as a "rescue therapy" in patients whose hypoxia is refractory to LFNC, to try to prevent further escalation of respiratory support. For hypoxia, LFNC should be trialed first, as many patients respond to LFNC alone and do not require HFNC (see HFNC Policy and Procedure - Addendum C: HFNC Initiation Considerations). When HFNC is being initiated, recommend starting with max settings as outlined in the HFNC Policy and Procedure - section D. HFNC may be used in Fox Valley - Acute Care and Milwaukee campus West 12 unit based on bed availability, nursing capacity, and the criteria below:

1. Fox Valley Pediatric Unit: HFNC < 25 LPM and FiO2 < 60%.
2. Milwaukee Campus W12 Unit: Patient must be ≤ 24 months of age and on settings ≤ 2 LPM/kg and ≤ 15 LPM (due to equipment) and ≤ 0.60 FiO2 (60% oxygen). Max of 5 HFNC patients on W12 at a time. See HFNC Policy and Procedure - Addendum B: HFNC Use in Acute Care – West 12) for details.
    - Of note, the RCP and provider should discuss initiation of HFNC when indicated; the provider must enter the order for HFNC. The attending provider (or overnight hospitalist) should be notified by the resident team when initiating a patient on HFNC.

G. Location Specific Admission Considerations:

1. Milwaukee Campus Respiratory Admission Guidelines
2. Fox Valley Campus Admissions: Children with bronchiolitis requiring HFNC < 25 LPM and FiO2 < 60%. Case-by-case discussions with Fox Valley PHM are required.

H. Admission Process

1. Order the RCS Bronchiolitis Protocol (see Annotation I below)
2. Hydration/Nutrition orders (see Annotation J)
3. Fever—consider fever evaluation based on age and clinical symptoms.
    - Infant 0-60 days old: Per the AAP febrile neonate guidelines, "Although the presence of documented respiratory viral infections decreases the risk of invasive bacterial infections in febrile infants, it remains unclear how a positive viral test result should influence further laboratory evaluation and management." Recommend referencing the Febrile Neonate Guideline for neonatal sepsis workup recommendations by age group.
    - Infant > 60 days old with bronchiolitis have a source for the fever and no workup is likely necessary. However, if fever is prolonged, patient is ill appearing or additional symptoms are present that may not be consistent with bronchiolitis, then additional workup may be warranted, including a CXR as well as evaluation for other sources of secondary bacterial infection.
4. RSV immunization status (see Annotation C-7)

I. RCS Bronchiolitis Protocol: RT will assess and score all patients in protocol and order the following:

1. Nasal and Nasopharyngeal (NP) suction as needed: Both types of suctioning clear secretions from the airway, which is thought to decrease work of breathing and improve oral intake. There is no evidence to suggest that NP suctioning is superior to nasal suctioning. Frequency of suctioning appears to be more important than mode (nasal vs NP).
2. Pulse oximetry orders: Continuous pulse oximetry is used for all patients receiving supplemental oxygen. Patients with bronchiolitis off of oxygen for 1-4 hours should be transitioned to spot checks of SpO2 with vitals. Continuous pulse oximetry may be indicated for patients with significant comorbidities (chronic lung disease, neuromuscular weakness, etc) or other risk factors (history of apnea).
3. Oxygen as needed to maintain saturations ≥ 90%

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Annotations (J-M)

J. Hydration Management begins with a PO trial (suction infant then allow parent to attempt to feed). Nasogastric or intravenous fluids should be considered for infants with bronchiolitis who cannot maintain hydration orally.

1. Adequate oral intake per hour can be calculated using the 4, 2, 1 rule:
   - <10kg: 4mL X Wt (kg) = goal intake in mL/kg/hour
   - 10-20kg: (40mL) + (2mL*(Wt(kg)-10)) = goal intake in mL/kg/hour
   - >20kg: (60mL) + (1mL*(Wt(kg)-20))= goal intake in mL/kg/hour to max of 2.5 to 3 L/day
2. Patients are generally able to PO feed while on HFNC. Nursing will perform pre- and during-feed assessments. If there are concerns with feeding Speech Therapy will be consulted to evaluate the safety of feeds. If the patient is consistently tachypneic and unable to PO feed, an NG tube should be considered for enteral feeds. No alternations to standard NG care are required for patients on HFNC.
3. If escalating beyond HFNC, consider making NPO with IVF in case intubation is needed.

K. Adjunct Therapies: Use of the following are NOT routinely indicated for bronchiolitis. Their use may be considered in certain clinical scenarios as discussed below.

1. PEP therapy: There is minimal evidence that PEP therapy is of benefit in bronchiolitis. Locally, it is felt there may be benefit in the setting of atelectasis, and it is currently an adjunct therapy in the bronchiolitis protocol. Albuterol does not need to be given in conjunction with PEP.
2. Albuterol: Albuterol should not be routinely administered to infants with bronchiolitis and routine trials are not recommended. Wheezing in bronchiolitis is more likely secondary to cellular debris and mucus, so bronchodilators are typically not helpful. Due to diagnostic overlap, an albuterol trial may be considered for diagnostic purposes for patients with:
   1. History concerning for asthma (recurrent acute wheezing episodes, asthma-like symptoms between episodes, history of responsiveness to albuterol)
      - May also consider family history of asthma in a 1st-degree relative and/or personal history of atopy but these are not specific for asthma
      - Race/ethnicity should not be used as a risk factor for asthma
   2. History concerning for chronic lung disease (prematurity <32 weeks or known CLD)
   3. Persistent wheezing and worsening distress despite suctioning

   Albuterol trials are not part of the RCS protocol and can only be ordered per physician discretion. Pre/post treatment assessments should be performed to determine if bronchodilators are beneficial; the RCP should be contacted for assistance with pre and post assessment and bronchiolitis scoring. If the bronchiolitis score improves, the provider may order scheduled bronchodilator but should reassess daily for continued need.
   Albuterol dosing by weight:
   - *for patients <5 kg* : 1.25mg/0.25mL or 2 puffs MD
   - *for patients >5 kg*: 2.5mg/0.5mL or 4 puffs MDI
3. Steroids: Steroids should not be routinely used in management of bronchiolitis. We recommend considering steroids only if a patient has a working diagnosis of bronchiolitis triggering asthma exacerbation and is consistently responding to bronchodilators, or in a patient who has underlying chronic lung disease.
4. 3% Hypertonic Saline: Nebulized hypertonic saline may be used in infants hospitalized for bronchiolitis in select clinical scenarios, but randomized control trials show inconsistent findings for routine use. Per the AAP guidelines, "Physiologic evidence suggests that hypertonic saline increases mucociliary clearance in both normal and diseased lungs. Because the pathology of bronchiolitis involves airway inflammation and resultant mucus plugging, improved mucociliary clearance should be beneficial, although there is only indirect evidence to support such an assertion." Its use may shorten hospital stay if length of stay is greater than 72 hours but may cause wheezing and excess secretions.
5. Racemic epinephrine: Racemic epinephrine should not be routinely administered to infants and children with a diagnosis of bronchiolitis. This may be used as a rescue agent in a deteriorating patient for severe respiratory distress and/or if there is felt to be a component of croup.

L. High risk patients: Patients with a history of prematurity (< 37 weeks gestational age), currently < 2 months of age, apnea during illness course, required PICU stay, or had a more severe presentation.

M. Posthospitalization Follow Up: The BeneFIT trial demonstrated that recommending follow-up as needed (rather than scheduling a PCP follow up) leads to less unnecessary healthcare utilization, equal clinical outcomes, and equal parental comfort/anxiety. Scheduled follow up can be considered for atypical bronchiolitis presentations or other needs.

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Appendix A: RSV Immunization

What are the options for RSV Immunization?

- RSV vaccine (Abrysvo) given during pregnancy: Given between 32-36 weeks gestation. Must be given ≥ 14 days prior to delivery to ensure enough time for antibodies to form, cross the placenta, and protect the infant. Of note, only currently administered September-January in the United States.
- RSV long-acting monoclonal antibodies administered to infants:
    - Nirsevimab (Beyfortus, on formulary at Children's Wisconsin, available October 1st - March 31st)
    - Clesrovimab (Enflonsia)

Who should get RSV immunization (Nirsevimab)?

- Infants <8 months of age if:
    - Pregnant person did not receive RSV vaccine during this pregnancy
    - Pregnant person's RSV vaccination status is unknown
    - Infant was born <14 days after the pregnant person's RSV vaccination
- Infants 8-19 months of age at high risk of severe RSV disease, regardless of the RSV vaccination status of the pregnant person or the child's prior receipt of nirsevimab or clesrovimab during their first RSV season. High-risk criteria include:
    - Children with chronic lung disease of prematurity who required medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) at any time during the 6-month period before the start of the second RSV season
    - Children with severe immunocompromise
    - Children with cystic fibrosis who have either manifestations of severe lung disease or weight-for-length that is less than the 10th percentile
    - American Indian or Alaska Native children (higher observed rates of severe RSV disease likely associated with social drivers of health)
- RSV immunization may also be considered for infants born to a vaccinated pregnant person when:
    - Infants born to pregnant people who may not mount an adequate immune response to RSV vaccination (eg, pregnant people with immunocompromising conditions)
    - Infants born to pregnant people who have medical conditions associated with reduced transplacental antibody transfer (eg, pregnant people living with HIV infection)
    - Infants who have undergone cardiopulmonary bypass or extracorporeal membrane oxygenation (ECMO), leading to loss of maternal antibodies
    - Infants with substantial increased risk for severe RSV disease (eg, hemodynamically significant congenital heart disease, intensive care admission with a requirement of oxygen at discharge)

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Please contact clinicalguidelines@childrenswi.org for questions or comments.

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